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The Pathological Extensions of Love

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Background. Clarification is still required of the nature of pathological love.
Method. A series is presented of 16 personally assessed cases with pathologies of love (erotomania).
Results. The pathologies of love usually involve a mixture of morbid infatuation and a morbid belief in being loved. They occur both in a symptomatic form, as part of an underlying mental illness, as well as in a pure form, where their emergence is to some extent understandable in a vulnerable personality. These disorders often go unrecognised to the detriment of clinical management.
Conclusions. Pathologies of love create distress and disruption to the patient, and place the objects of their unwarranted affection at risk of at best harassment and at worst violence. Although this series of cases, which is drawn predominantly from forensic practice, overemphasises the risk of overt violence, the distress occasioned by pursuit and harassment alone should not be underestimated.

The pathological extensions of love have appeared under various guises in the literature, including the monomania of Esquirol (1845), Krafft-Ebing's (1879) erotic paranoia, Kraepelin's (1913) erotomania, Kretschmer's (1918) erotic self-reference delusions, Hart's (1921) old maid's insanity, de Clérambault's syndrome (1942), and Seeman's (1978) delusional loving. 'Erotomania' is the term which has come to dominate psychiatric discourse. In addition to describing a pure or primary disorder, the literature documents this syndrome in association with schizophrenia (Hayes & O'Shea, 1985), affective disorders (Rudden *et al*, 1990; Raskin & Sullivan, 1974), schizoaffective disorder (Gillet *et al*, 1990), and a variety of organic psychosyndromes (Lovett Doust & Christie, 1978; Drevets & Rubin, 1987; Singer & Cummings, 1987; Gaddall, 1989).

Pathologies of love occur in men and women, the homosexual and the heterosexual, in both Western and non-Western cultures (Taylor *et al*, 1983; Dunlop, 1988; Eminson *et al*, 1988; El-Assra, 1989). They are regarded as a rarity, being reported in 0.3% of in-patients (Retterstol & Opjordsmoen, 1991) and in some 10% of delusional disorders (Rudden *et al*, 1983), but this may reflect as much a failure of recognition as a paucity of cases.

The history of the term 'erotomania' has been traced, and such analysis helps place any current debate in context, but dissecting the manner in which a word has been used in the past cannot resolve clinical issues. The nosological assumptions about erotomania, bequeathed to us by history, need to be exposed to the tests of adequacy and clinical value.

The nature of love has tended to be the province of poets, novelists and artists, although it has attracted a scholarly literature (Singer, 1966, 1987; Barthes, 1977; Scruton, 1986; Solomons, 1981; Fisher, 1990). There would appear to be general agreement that the infatuation of falling in love and being in love are separable states of affairs. Infatuation does not necessarily require any response, let alone intentional encouragement, from the object of affection. Sympathy and identification can similarly flourish at least for a time in a one-sided relationship. The state of being in love requires some mutuality of attraction, desire and benevolent concern, and without a positive response from the beloved the progress from infatuation to being in love is blocked.

Unrequited love usually withers but occasionally the lover, by an act of self-abnegation, continues to love without demanding any return (Fisher, 1990). The other way forward from a lonely, idiopathic erotic fixation is to resort to fantasy or delusion to replace the lack of response from the beloved. It is here we begin to move into the traditional area of erotomania. The tragedy for the patients described in this paper is that love has become an isolating and autistic mode of being, in which any possibility of unity with another is lost. The tragedy for those on whom they fix their unwanted attentions is that, at the very least, they suffer harassment and embarrassment, and at worst they may fall victim to the violent expression of resentment, jealousy, or sexual desire. The increasing awareness of the potential threat presented by these disorders is

Table 1
Clinical characteristics

Patient no.	Age	Sex	Diagnosis	Age at onset	Concomitant disorders	Age at onset of erotomania	Type of erotomania	Morbid infatuation	Morbid belief in being loved
1	47	F	Delusional disorder	43	Major depression	43	Pure	+ +	+ +
2	44	F	Delusional disorder	42	Anxiety disorder	42	Pure	+	+ + +
3	42	M	Delusional disorder	41	-	41	Pure	+ + + +	-
4	36	M	Delusional disorder	28	-	28	Pure	+ + + +	-
5	49	M	Delusional disorder	37	-	37	Pure	+ + +	+
6	50	M	Schizophrenia	20	-	27	Symptomatic	+ +	+ +
7	33	M	Schizophrenia	28	Substance abuse	28, and 31	Symptomatic	+ +	+ +
8	38	M	Schizophrenia	19	Major depression	34	Symptomatic	+ +	+ +
9	48	M	Schizophrenia	28	-	40	Symptomatic	+ + + +	-
10	30	F	Bipolar disorder	30	Substance abuse	30	Symptomatic	+ +	+ +
11	50	M	Schizophrenia	20	Capgras' syndrome	27	Symptomatic	+	+ + +
12	28	M	Schizophrenia	18	Capgras' syndrome	21	Symptomatic	+ + +	+
13	28	F	Bipolar disorder	24	-	24, and 26	Symptomatic	+ +	+ +
14	32	F	Bipolar disorder	24	-	26	Symptomatic	+ +	+ +
15	30	M	Schizophrenia	19	Substance abuse	27	Symptomatic	+ +	+ +
16	41	M	Alcohol dependence with hallucinosis	34	Sexual sadism	39	Symptomatic	+ + + +	+ +

+, + +, + + +, + + + + represent increasing morbid infatuation and morbid beliefs in being loved. -, not present.

Table 2
Personal histories

Patient no.	Relationship with		No. of siblings	Birth order	School adaptation		Marital status[1]	Employment	Predominant sexual orientation
	mother	father			academic	social			
1	Close	Distant	4	4	Good	Poor	M	Accounts clerk	Problematic
2	Distant	Distant	0	1	Good	Poor	M	Typist	Heterosexual
3	Close	Poor	7	3	Average	Good	S	Salesman	Heterosexual
4	Close	Distant	0	1	Average	Poor	S	Tradesman	Problematic
5	Close	?	2	1	Average	Poor	S	Clerk	Problematic
6	Close	Close	3	1	Poor	Poor	S	None	Heterosexual
7	Absent	Distant	3	3	Poor	Reasonable	D	Labourer	Heterosexual
8	Absent	Absent	2	1	Good	Reasonable	D	None	Heterosexual
9	?	?	0	1	Poor	Poor	S	Professional	Heterosexual
10	Poor	Poor	0	1	Poor	Poor	S	Unemployed	Problematic
11	Poor	Absent	2	2	Poor	Poor	S	Unemployed	Heterosexual
12	Close	Poor	1	2	Average	Average	S	Unemployed	Homosexual
13	Poor	Poor	4	2	Good	Poor	S	Clerk	Heterosexual
14	Distant	Good	5	1	Good	Good	M	Professional	Heterosexual
15	Poor	?	1	2	Good	Average	S	Unemployed	Heterosexual
16	Close	Absent	3	1	Average	Average	D	Security guard	Heterosexual

1. S is for single, M for currently married and D for divorced or separated.

leading to an explosion in legislation designed to protect victims from such unwanted attention (Perez, 1993).

This paper critically examines the current formulations of the pathologies of love, and in particular the centrality accorded an erotomania constructed around a delusion of being loved. Pathologies of love are most often found embedded in a psychotic illness such as schizophrenia. Although most commentators accept the existence of a pure syndrome, others question this (Ellis & Mellsop, 1985). Some of our cases are properly regarded as primary pathologies of love. The spectrum of clinical characteristics found in the pathologies of love are discussed.

Method

The clinical material comprises 16 patients personally assessed, and in most instances managed, by the authors between 1990 and 1993. All these subjects had at least one extended episode of disturbance in which the central clinical feature was a pathology of love. We work predominantly in a forensic context, which imparts a bias to the case material. Most of our patients are men, and were referred either via the justice system or from the general psychiatric services because they raised issues of dangerousness. Cases 13 and 14 were the only ones encountered outside of our forensic practice. The case material usually included extensive data gathered from the objects of the patients' unwanted attentions, often in the form of victim impact reports or statements of complaint.

Tables 1 to 3 provide the basic information on the patients' clinical characteristics, personal history and personality, while Table 4 describes those upon whom they fixed their attention. The information provided omits or alters those potentially identifying aspects not central to an understanding of the case to protect the identities of the patients and their victims. The diagnostic grouping for the discrete syndromes is that of delusional disorder, as they all fulfilled the DSM-III-R criteria (American Psychiatric Association, 1987) for this condition but, as discussed below, this needs to be interpreted with caution.

Morbid infatuations and morbid beliefs in being loved

Morbid beliefs of being loved are characterised by:

(a) a conviction of being loved
(b) the supposed lover doing nothing to encourage or sustain the belief, but on the contrary usually making clear a lack of interest and concern
(c) the words and actions of the supposed lover being reinterpreted to maintain the belief in requited love

Table 3
Previous personality

Patient no.	Personality disorder (DSM-III-R criteria)	Sensitive ideas of reference	Marked dependent traits	Marked narcissistic traits	Grandiosity	Social incompetence
1	Avoidant	Yes	Yes	No	No	Yes
2	Avoidant with obsessive-compulsive traits	Yes	Yes	No	No	Yes
3	Narcissistic	Yes	No	Yes	Yes	No
4	Paranoid	Yes	Yes	Yes	Yes	Yes
5	Narcissistic with obsessive-compulsive traits	Yes	Yes	Yes	Yes	Yes
6	-	Yes	Yes	Yes	Yes	Yes
7	Antisocial	Yes	No	Yes	No	No
8	Antisocial	Yes	No	No	Yes	No
9	-	Yes	No	No	No	Yes
10	Antisocial	No	No	No	Yes	No
11	Schizoid	Yes	No	No	No	Yes
12	-	No	No	Yes	Yes	No
13	-	No	No	No	No	Yes
14	-	No	No	No	No	No
15	Paranoid	Yes	No	No	No	Yes
16	Paranoid, and antisocial	Yes	No	Yes	Yes	Yes

(d) a belief that the supposed relationship will eventually be crowned by a permanent and loving relationship
(e) preoccupations with the supposed love forming a central part of the subject's existence
(f) repeated attempts to approach the supposed lover, creating, at the very least, embarrassment and distress to both parties.

Although there is usually an implicit acceptance in the literature that erotomania involves infatuation as well as a belief in being loved, a minority of writers allow the possibility of a disorder centring exclusively upon morbid infatuation (Kretschmer, 1918, 1952; Sims, 1988), although cases of what would appear to be pure morbid infatuations have been described (Esquirol, 1845). In the trial of John Hinckley Jr, who attempted to assassinate President Reagan, evidence given indicated that he did not have erotomania because, although he had an all-consuming infatuation with Jodi Foster, he at no time entertained the belief that she loved him or even returned his interest (Low *et al*, 1986; Meloy, 1989).

This focus on the belief of being loved is understandable, for it can usually be shown to be both false and sustained by interpretations which persistently run counter to the meanings which could reasonably be attached to the proffered evidence. Thus case 1 said the love of her object of affection was conclusively revealed by his complaints about the difficulties he had encountered with the traffic driving to work, and case 6 saw undying affection expressed by the way a young lady patted her handbag while sitting in a bus. In contrast, it is difficult, if not impossible, to falsify a statement that one is in love with another, particularly when no accompanying claim is made that the affection is returned. But does this mean that there can be no pathological infatuation?

In case 4 the patient doggedly pursued his "God chosen bride" over several years. His life became dominated by the quest, and all his other interests were subordinated. He created chaos for the object of his affections, put the lives of others in danger, and totally destroyed the fabric of his own life, culminating in long-term incarceration. Throughout this time he never claimed that the object of his affection returned his love, stating only that if others stopped poisoning her mind against him she might come to return his affection. In case 3, throughout the months of unremitting pursuit of his love object, he acknowledged that she was now frightened of him, she had never loved him, and that the only hope was "starting over afresh from the beginning". In these cases, as with all infatuations, there was a hope of eventual union and fantasies of fulfilment, but there was no belief that their love was reciprocated.

Some infatuations can surely be regarded as morbid by virtue of both the associated states of mind and the behaviour, with its effect on the lives both of the sufferer and the object of the unwanted affection. There is a continuity between the infatuations of normal teenagers and lonely adults and these morbid states, but though the differences

Table 4
Objects of patients' affections

Patient no.	Age	Social status	Marital status[1]	Nature of previous contact	Duration of harassment	Impact on victim
1	50+	Senior executive	M	Employer	4 years	Disruption at home and work, marital friction created, threatened, assaulted
2	40+	Clergyman	M	Slight social	2 years	Disruption at home and work, victim of false accusations
3	42	Senior executive	S	Brief relationship	1 year	Disruption at work and home, threatened, assaulted, receiving treatment
4	16	Schoolgirl	S	Slight social	8 years	Disruption at home and socially, pursued, emigrated
5	24	Singer	S	Seen performing	1 year	Attacked and killed
6	20s	Nurse	S	Her patient	6 months	Fear and distress, sexual assault - period off work
	30s	Doctor's wife	M	Seen when attending her husband	3 months	Fear and distress
	15	Schoolgirl	S	Seen in street	6 months	Sexual assault, considerable ongoing distress, receiving treatment
	30s	Nurse	M	Her patient	9 months	Fear and distress
7	20s	Single mother	S	Seen in street	3 months	Fear and distress, sexual assault, needed therapy
	18	Student	S	Seen in street	2 years	Fear and distress, left university
8	40	Artist	D	Social, tried to help	4 years	Fear and distress, sexual assault, needed therapy
9	20s	TV personality	S	A fan of hers	1 year	Fear and distress
	30s	Doctor	M	Treated once	4 weeks	Embarrassment
10	40s	Senior policeman	M	Arrested her	8 weeks	Nuisance and embarrassment
11	14	Schoolgirl	S	Seen in street	years	Fear and distress, sexual assault
12	20s	Actress	S	Saw in films	7 years	Fear and distress
13	30s	Manager	M	Supervisor at work	6 weeks	Embarrassment
	30s	Lecturer	S	Attended his lectures	3 months	Embarrassment and distress
14	30s	Doctor	M	Seen once	4 weeks	Embarrassment
15	30s	Nurse	S	Slight social	1-2 years	Fear and distress
16	30s	Social worker	S	Her client	3 years	Fear and distress, assaulted - period off work

1. S is for single, M for currently married and D for divorced or separated.

may be one of degree, their extreme nature also involves fundamental changes in the patient's world view.

Morbid infatuations are characterised by:

(a) an intense infatuation without the need for any accompanying conviction that the affection is currently reciprocated
(b) the object of the infatuation either doing nothing to encourage the feelings or clearly and repeatedly rejecting any continuing interest or concern
(c) the infatuation preoccupying the patient to the exclusion of other interests, resulting in serious disruption of their lives
(d) the subject insisting on the legitimacy and possible success of the quest
(e) a persistent pursuit of the object of affection, often with gradually escalating intrusiveness
(f) significant distress and disturbance, usually occasioned to the object of the infatuation.

In this series of pathological extensions of love, most cases exhibit both morbid infatuation and the morbid conviction of being loved, with individual cases having more or less of one or the other (Table 1). Cases 3, 4 and 9 are morbid infatuations with no real conviction of being loved in return. Case 2 claimed initially to have no interest in the attentions of her supposed lover but later admitted being seduced by his enthusiasm. The three individuals (5, 9, 12) in our sample who stalked prominent media personalities were all predominantly infatuated, with one (9) having no conviction in his affections being reciprocated.

Nosological status of pathologies of love

Pathologies of love, like the closely related pathological jealousies, cover a spectrum which at one end overlaps with extreme examples of such reactions in otherwise normal people, and at the

other with bizarre variants which are to be found embedded in a schizophrenic psychosis. Extracting a clear description of these disorders from the chaotic richness of clinical realities presents formidable difficulties.

Symptomatic (secondary) pathologies of love

Pathologies of love are most frequently encountered as part of recognisable psychiatric syndromes. In theory, any condition capable of giving rise to delusions can generate a pathology of love. DSM-III-R credits erotomania with being an occasional symptom of 22 categories of disorder, ranging from schizophrenia to multi-infarct dementia.

The features of the secondary pathologies of love are:

(a) that they owe their genesis and evolution to an underlying mental disorder which emerges before, or with, the pathology of love
(b) the clinical features of the underlying disorder are present alongside the pathology of love
(c) they usually resolve as the underlying disorder resolves.

Symptomatic pathologies of love tend, both in our own and reported cases, to differ from the pure syndromes. They tended to be more fickle, with more than one object of love (6, 7, 13) (Table 4). In case 13, with a manic illness, when the erotomania recurred it took a different object and in some of those with schizophrenia the object of affections shifted with time and circumstance (6, 7, 11). In one case (11), though different women were fixed upon, the patient often claimed they were his original object of affection in disguise. The onset was usually abrupt. The carnal rather than the sentimental aspects of love were often prominent, with overtly sexual fantasies and approaches (see Table 4). Cases 6, 7, 8 and 11 all made sexual attacks on the object of their affections varying in severity from indecent assault to determined attempts at rape. Necrophilic fantasies and a history of sexual sadism in case 16 occasioned considerable anxiety about the safety of the object of this man's attentions.

The pathologies of love in the symptomatic group appeared to have their origins primarily in the underlying disorder rather than in the personality and background of the patient, although there may well have been pathoplastic influences which directed the patient's state of mind towards love rather than, for example, jealousy or persecution. The premorbid personalities of the symptomatic syndromes showed no consistent pattern (Table 3). In some cases of early-onset schizophrenia (6, 8, 11, 12, 15), it was difficult to distinguish the prodrome to the illness from possible pre-existing personality deviations. Similarly, although intense self-consciousness and sensitive ideas of reference were reported before the diagnosis of schizophrenia in cases 6, 7, 8, 9, 11, and 15, it is probable that they were a feature of the emerging disorder. In contrast, the antisocial traits in cases 7, 8 and 10 clearly predated the onset of illness and in all three were in continuity with conduct disorders in childhood.

The course of the symptomatic pathologies of love were directly linked to the progress of the underlying disorder. When the syndrome emerged in the context of a manic episode, they resolved rapidly as the mood returned to normal (cases 10, 13, 14). Subsequently these three women experienced considerable embarrassment about their behaviour. In schizophrenia the course mirrored fluctuations in the patient's condition, although relapse was not necessarily connected to a return of the pathology of love (9, 11, 15).

Pure (primary) pathologies of love

The basic characteristics of pure or primary pathologies of love are:

(a) the pathology of love forms the totality of the clinical picture
(b) the emergence of the disorder is usually to some extent understandably related to the patient's personal and social situation as well as underlying character structure
(c) there may be some 'provoking' event temporally related to onset.

The central feature of the pure pathologies of love is that they are discrete entities unaccompanied by features of other disorders, although it is important not to confuse a disorder generating the erotomania with a depressive episode developing secondarily to the distress and disturbance. The emergence of pure erotomania is often related to a current lack of an intimate relationship and may be precipitated by a loss or 'narcissistic' wound (Enoch & Trethowan, 1979; Evans *et al*, 1982). Cases 1 and 2 were married women who believed their relationships lacked intimacy. In one, sexual relationships had ceased many years previously, and in the other they were without excitement or novelty. Cases 4 and 5 lived lives bereft of social outlets, let alone sexual contact, and the other (3) had only the most superficial of acquaintances. The onset was preceded by the loss of their only close male companion (4, 5), the failure of a valued relationship (3), the failure to obtain a long overdue promotion (1), and the loss of long-standing employment (2).

The premorbid personality in pure cases has variously been described as shy and awkward (Krafft-Ebing, 1879), hypersensitive (Kretschmer, 1918), proud and rebellious (de Clérambault, 1942), narcissistic (Enoch & Trethowan, 1979), schizoid (Munro *et al*, 1985), lacking in confidence, suspicious and socially avoidant (Retterstol & Opjordsmoen, 1991), and timid and withdrawn (Seeman, 1978). The common features in these descriptions is of a socially inept individual isolated from others, be it by sensitivity, suspiciousness, or assumed superiority. These people tend to be described as living socially empty lives, often working in menial occupations and being, or feeling themselves to be, unattractive (Segal, 1989). The desire for a relationship is balanced by a fear of rejection or a fear of intimacy, both sexual and emotional.

Three of our cases (1, 2, 5) were shy, self-effacing people with low self-esteem, and all five tended to be self-referential and suspicious (Table 3). Cases 3 and 4 presented as self-confident to the point of grandiosity, which could translate into a degree of sociability and charm, albeit superficial. The apparent self-confidence of these two men was easily punctured, and both tended to become intensely suspicious and accusatory in response to the slightest rebuff. All of these people were at the time the disorder emerged facing a life which appeared to them bleak, unrewarding, and bereft of intimacy.

In all the pure syndromes, we noted an exquisite self-consciousness and tendency to refer the slightest actions or utterances of others to themselves, usually endowing them with a denigratory or malevolent colouring (Table 3). It is not difficult to extrapolate from such a tendency to the development of a pathology of love, given that all that may be required to set such a development in motion is seeing the actions and utterances of one particular person not as malevolent but as loving.

The onset of the pure syndromes tended to be gradual, with many weeks of increasing preoccupation with the supposed beloved followed by a crystallising out of the erotomanic beliefs. The sudden 'explosive' onset described by de Clérambault (1942) was not found, the commencement in our cases being far closer to that described by Kraepelin (1913).

Previous reports of the frequency of distant or absent fathers (Trethowan, 1967; Seeman, 1978) were confirmed in our cases (Table 2). The sexual orientation in three cases was problematic, with one woman having sought counselling because of her difficulties in this area, another acknowledging resisted but long-standing homosexual inclinations, and one having previous homosexual contacts (Table 2). In very broad terms, though able academically at school, this group had not achieved their potential, socially or occupationally. They all expressed frustrations about a lack of fulfilment in their interpersonal lives. The marked social ineptitude and shyness which characterised four of the five probably contributed to their lack of success.

Case 2 illustrates many of the features found in the pure syndromes.

Case 2

K was the only child of elderly and unsupportive parents. As a child she described herself as intensely self-conscious and easily frightened, with no close friends. Although she was able academically, she did not enter university, opting instead for a commercial course and a position as a typist. Her husband was her first and only boyfriend. The marriage went badly from the outset and there were considerable sexual difficulties. They had few shared interests and there was little intimacy. Her work provided the only arena of social interaction. A few months before the onset of symptoms she lost her job because the firm closed.

She had poor self-esteem and acknowledged that she had always been somewhat suspicious of others and tended, when in public places, to feel that people looked at her, laughed at her behind her back, and made derogatory remarks. She was very concerned with order and cleanliness, and had a number of cleaning and checking rituals.

She was referred from the courts following a breach of a restraining order and charges arising out of telephone calls to a local clergyman. K explained that she had been the object of the romantic intentions of this particular clergyman for several years. Following her first meeting with him, she noted he regularly drove past her house and waved to her. She suspected that at night he would clamber up trees behind the house to watch her undress. She never actually saw him, but claimed that she knew he was there. She also reported that he began to communicate with her by barely audible blips which could be heard from the telephone, both when the receiver was in place and when she lifted the receiver. She was initially discomforted by his attentions, but gradually began to realise that they were the manifestations of a shy man in love with her. She began to return his telephone calls. She said that he always denied having made a call, and she realised that this was a "friendly game" which was meant to entice her into an increasingly profound relationship. She began to telephone more frequently, and finally declared her love. His apparent surprise and disavowal she recognised were because he was still married and would have to disentangle himself from his present encumbrances before they could be united.

The clergyman became increasingly distressed, and after the failure of mediators to dissuade her from further contact he obtained a restraining order. She noted however that at the same time he increased his covert communications via the blips and squeaks emanating from the telephone. She kept a meticulous record of these supposed communications, which occurred anything up to 150 times a day. He obtained an ex-directory number, but she soon

discovered it. The clergyman claimed that his life was now totally disrupted by her calls and her other communications.

This lady was absolutely convinced that the clergyman loved her and intended to marry her. She said that he began the contact, and that he still remained the one more intensely in love. She had no difficulty in explaining all his words and actions, even that of taking her to court, as covert expressions of undying devotion. There were no hallucinatory phenomena, the noises from the telephone most probably being illusions. There were no other abnormalities in her mental state.

This lady responded remarkably well on 4 mg pimozide a day. The absorption with the supposed lover rapidly decreased, going from a virtually total domination of her waking thoughts to an occasional consideration of the matter. She continued to assert that this man had approached her, but increasingly she would both disavow any interest in him and accept that he no longer retained any interest in her. The relationship with her husband improved for the first time and they began to communicate and enjoy something approaching a marital relationship. Six months later, on her own initiative, K stopped the pimozide. There was a rapid return of symptoms and within a matter of weeks she was again plaguing the clergyman with letters and telephone calls. The reintroduction of pimozide produced another gratifying resolution. She remains on regular medication.

The lives of the five cases with discrete syndromes were totally disrupted by the pathology of love. It came to dominate their lives and despite loss of job (cases 1, 3, 4), criminal prosecution (1, 2, 3, 4), and even incarceration in prison (3, 4) or hospital (1, 2, 3, 4), they persisted in their pursuit.

The boundaries of normality

The model advanced in this paper with regard to the pure syndromes is that they are extensions of the passion of love forming a continuum which at one end may overlap with excessive and exuberant manifestations of love, and at the other extreme encompass clearly delusional states. This leaves the boundaries between the normal and the pathological ill defined. In this respect, the pathological extensions of love resemble those of jealousy. In jealousy, however, the tendency is for definitions of psychopathology to annexe much of the normal emotion (Mullen, 1992). In love the opposite tendency manifests, with the madness of love being looked on benignly as the product of enthusiasm and commitment. We overdiagnose pathology in the jealous and may equally overlook disorder in those who claim the excuse of love.

The boundary issues are particularly acute in instances where there has been some form of real relationship, however fleeting, between the individual and the object of affection. That the feelings were intentionally encouraged at some stage and even reciprocated makes it difficult subsequently to designate the love as pathological. One solution is to exclude such cases from consideration, but in so doing we believe occasional dramatic examples of pathology will be missed. (Currently in our culture the best-known example of erotomania is that portrayed in the film *Fatal Attraction*, which begins with a brief affair.)

The pains of love

The effects of the patient's behaviour on the objects of affection are summarised in Table 4. The lives of the victims were disrupted by telephone calls, letters, and in most cases repeated approaches. Several were physically assaulted, and five were sexually assaulted. Case 5 in a jealous rage attacked and killed the object of his affections. Two of the victims moved town and one emigrated to avoid pursuit. Four women required psychiatric treatment because of the distress occasioned by the actions of these patients. (Further details will be provided in Mullen & Pathé, in press.)

The patient's lives were dominated by the pathological loving and they suffered both the pain of unrequited love and brought on themselves, at the very least, embarrassment, and at worst long-term incarceration. It might be wondered what gains accrued to these patients from their love. Scheler (1912), in his classic study of the phenomenology of love, suggested that we do not love someone because they give us pleasure but because we experience joy through loving. The act of love, even if unrequited, is itself still accompanied by a feeling of great happiness, regardless of whether it occasions pain and sorrow. For those whose life is empty of intimacy, the rewards of even a pathological love may be considerable.

Prevalence

Pathological extensions of love may be missed when they are part of an ongoing disorder such as schizophrenia. The discrete syndromes may well not be brought to the notice of mental health professionals unless the behaviour becomes so outrageous it cannot be ignored. Eleven of the cases presented here had had considerable contact with the mental health services, but in only three had the diagnosis of erotomania even been raised, only to be dismissed in two.

Those with delusional disorders do not usually regard themselves as psychiatrically ill, and they are to be found not in mental health clinics but in the

context appropriate to their convictions. Paranoid litigants frequent the courts, delusional infestations attend dermatologists, the morbidly jealous pursue their partners, and the erotomanics plague the objects of their affections. The prevalence of pathologies of love will probably be best estimated by collecting data from the objects of unwanted attentions.

Management

There is a misplaced pessimism about the management of these conditions. In the symptomatic disorders, treatment is directed at the underlying illness, with the pathology of love requiring containment to prevent distress to the patient and disturbance or danger to the object of affections. The response to treatment in the symptomatic disorders reflected the nature and severity of the underlying disorder, with manic illnesses (10, 13, 14) recovering completely, but those with intractable schizophrenic disorders (6, 8, 12, 15) continuing to harbour erotomanic delusions.

The linchpin of treatment in the pure syndromes is the use of antipsychotics, which are often effective in low to moderate dosage (1, 2, 3). It is often worth persisting with low-dose antipsychotics (e.g. 2–4 mg pimozide) for many months, as, coupled with supportive, albeit gently challenging, psychotherapy, they can produce a gradual amelioration and even resolution of the delusions. Active involvement of the spouse in cases 1 and 2 appeared helpful, although whether the improved marital relationship was the result of, or a contributor to, the waning of the disorder is uncertain. When the disorder is at its height, confronting the morbid beliefs is usually unproductive, although occasionally unavoidable, but once a response to medication begins, we believe discussion and confrontation do speed resolution. Long-term follow-up is advisable, with attention to the social and psychological realities of the patient's life which render the patient vulnerable to recurrence.

Conclusions

Pathologies of love potentially involve both morbid infatuations and morbid beliefs in being loved. They occur as part of a range of psychotic disorders, most particularly schizophrenia, and as pure entities which often fulfil the criteria for delusional disorders. These disorders may go unrecognised, to the detriment of clinical management.

The cases described in this paper cannot be assumed to constitute a representative sample. Compared with previous reported series there is greater intrusiveness and overt violence, and men predominate. This is a product of the forensic context, and is unlikely to reflect the pattern of these disorders in the community. These disorders are uncommon but by no means rare in our practice. A greater awareness that pathological extensions of love include a spectrum of psychopathology, with both pure and symptomatic variants, may increase the recognition of these conditions. The pathological extensions of love not only touch upon but overlap with normal experience, and it is not always easy to accept that one of our most valued experiences may merge into psychopathology.

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